MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07462

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GALESVILLE; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) AARON (Middle) (Last) BALLARD

4. DATE OF DEATH: (Month) AUG. (Day) 28 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: FEB. 17. 1924

9. AGE last birthday: 25 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FISHING

10b. KIND OF BUSINESS OR INDUSTRY: FISHERMAN

11. BIRTHPLACE (State or foreign country): Galesville Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lloyd Ballard

14. MOTHER'S MAIDEN NAME: Beatrice Browner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-14-9655

17. INFORMANT: Geneva Ballard

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bullet wound in Chest.

981 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Homicide.

166 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Galesville (CITY OR TOWN) A.A. (COUNTY) Md. (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): AUG. 28 1949 2:20 p.m. INJURY OCCURRED While at work ☐ Not while at work ☑ HOW DID INJURY OCCUR? Was shot with .38 cal. pistol

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

SIGNATURE: John M. Caffey (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 8-28-49.

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF: AUG. 31, 1949 | NAME OF CEMETERY OR CREMATORY: GROWNER CEM. | LOCATION (City, town, or county): GALESVILLE (State): MD

DATE REC'D BY LOCAL REG.: Aug. 29, 1949 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: T. A. HARDESTY + SON ADDRESS: GALESVILLE, MD.

RECEIVED
AUG 31 1949
BUREAU V. S.

Evidence for change of year of birth, shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07463

FILM No. G 121 SEP -2 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland | LENGTH OF STAY (in this place) 24 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland, Ferndale Md. P.O.
STREET ADDRESS (If rural, give location) 307 Orchard Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WALTER	C.	BECKER	Aug.	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Sept. 2, 1868	62 yrs.	11	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor (Retired) | 10b. KIND OF BUSINESS OR INDUSTRY Beth. Fairfield | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William G. Becker | 14. MOTHER'S MAIDEN NAME Mary Bowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 218-14-6349 | 17. INFORMANT Elizabeth O. Becker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	6 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	4 years.
	(c) Arterio-sclerosis	4 years.

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from June, 1947, to 8/22, 1949, that I last saw the deceased alive on 8/22/49, 19..., and that death occurred at 9.55 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave F. Rauch M.D.		Glen Burnie, Md	8/25/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug. 27, 1949	Holy Cross	Brooklyn A.A. Co.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/26/49	[signature]	Thomas W Singleton	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07464

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Jacobsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Beechwood, Magothy River

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1632 North Caroline

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) (Last) BLACKWELL
4. DATE OF DEATH (Month) Aug (Day) 7 (Year) 1949
5. SEX male
6. COLOR OR RACE negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH July 29 1924
9. AGE last birthday 25 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel
11. BIRTHPLACE (State or foreign country) Kenbridge Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME deceased
14. MOTHER'S MAIDEN NAME Hyacinthia Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) world war
16. SOCIAL SECURITY NO.
17. INFORMANT Warren Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

9294 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

183

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Magothy River (CITY OR TOWN) near Jacobsville (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Aug. (Day) 7 (Year) 1949 (Hour) 7 40 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Could not swim but was in water near Beechwood Park

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 8-7-49

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF Aug 11 49 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) Blackstone (State) Va.

DATE REC'D BY LOCAL REG. 8/9/49 REGISTRAR'S SIGNATURE L. W. Hedrick

24. FUNERAL DIRECTOR Mrs. Robt. U. Elliott & Dyk ADDRESS 1129 N. Caroline St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

H. T. Allen

07465

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 18 Taylor St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 18 Taylor St.

3. NAME OF DECEASED (Type or Print): (First) Alverta; (Middle); (Last) Brown

4. DATE OF DEATH: (Month) Aug. (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: May 18, 1894

9. AGE last birthday: 55 yrs. If under 1 year: Months 2 Days 17 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Titus

14. MOTHER'S MAIDEN NAME: Maggie Bonds.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Bertha Hutton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uterine Carcinoma with spread to vital organs — Interval Between Onset and Death: about 9 mos

174 Antecedent cause(s)

48b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) Annapolis | (COUNTY) aa | (STATE) md

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-11, 1948, to 8-3, 1949 that I last saw the deceased alive on 8-3, 1949, and that death occurred at 10:30 P. m., from the causes and on the date stated above.

SIGNATURE H. T. Allen (Degree or title) MD ADDRESS 10 Carroll DATE SIGNED 8-5-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Aug 7 1949 | NAME OF CEMETERY OR CREMATORY Brewers Hill | LOCATION (City, town, or county) Annapolis | (State) Md

DATE REC'D BY LOCAL REG. Aug. 5, 1949 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis, Md.

VS. A15

RECEIVED
AUG 8 1949
BUREAU V. S.

Dr. Basil

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07466

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Shipwright St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.; STREET ADDRESS (If rural give location) 91 Shipwright St.

3. NAME OF DECEASED (Type or Print): (First) Samuel (Middle) J. (Last) Carr

4. DATE OF DEATH: (Month) 8 (Day) 26 (Year) 1949

5. SEX: M.

6. COLOR OR RACE: W

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 1862

9. AGE last birthday: 87 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): A.A. County, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel J. Carr

14. MOTHER'S MAIDEN NAME: Margaret E. Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no

(If yes, give war or dates of service) no

16. SOCIAL SECURITY No.

17. INFORMANT: W. Clayton Carr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis Chr. with Myocardial Insufficiency	3 yrs
443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 934	(b) Hypertension	10 yrs
	(c) Arteriosclerosis generalized	10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to Aug 26, 1949, that I last saw the deceased alive on Aug 25, 1949, and that death occurred at 3 PM m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George Basil M.D. Annapolis Md 8.27.49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 8/28/49 | NAME OF CEMETERY OR CREMATORY St. Anne's | LOCATION (City, town, or county) Annapolis | (State) Md.

DATE REC'D BY LOCAL REG. Aug. 27, 1949 | REGISTRAR'S SIGNATURE W. J. Branch

24. FUNERAL DIRECTOR John M. Taylor & Son | ADDRESS Annapolis Md.

VS. A15

RECEIVED
AUG 31 1949
BUREAU V. S.

07467

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 624 Second street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural give location) 624 Second street

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) Nathaniel Carrol (Last)

4. DATE OF DEATH (Month) 8 / (Day) 31 / (Year) 1949

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH About 1885
9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) South River Anne Arundel Co.
12. CITIZEN OF WHAT COUNTRY? yes

13. FATHER'S NAME Charles E. Carroll
14. MOTHER'S MAIDEN NAME Sarah Colbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Newton Carroll

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

151 Immediate cause (a) Carcinoma of Stomach with spread to vital organs

46b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Annapolis (COUNTY) A. A. (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-18-49, 19....., to 8-31-49, 19....., that I last saw the deceased alive on 8-29-49, 19....., and that death occurred at 2:20 a.m., from the causes and on the date stated above.

SIGNATURE G. T. Allen (Degree or title) M D ADDRESS 10 Carroll DATE SIGNED 9-1-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/3/1949
NAME OF CEMETERY OR CREMATORY Annapolis Neck
LOCATION (City, town, or county) Anne Arundel Co. (State) Md.

DATE REC'D BY LOCAL REG. Sept. 3, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son ADDRESS 43-45 northwest

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 7 1949
BUREAU V. S.

Evidence for addition in #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

07468

2411 N. Charles Street, Baltimore

FILM No. G 122 SEP 30 1949

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL. STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: | LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5 SEVENTH AVE BROOKLYN PK

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MD COUNTY: ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park
STREET ADDRESS (If rural, give location): 5 - Seventh

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Henry	Chenowith.	8	30	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	May 7, 1893	56 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Chemical	Delaware	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George H. Chenowith	Margaret Hogan.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
no		Maryland Chenowith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Pulmonary edema	36 hrs
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac Failure, Chronic.	?
	(c) Arteriosclerosis - Chr. myocarditis; abdominal ascites;	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic gangrene of rt. leg -removal one year ago
Circulatory disturbance of lower remaining extremities.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	— (9/30/49- ams)	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-10, 1949 to 8-30, 1949, that I last saw the deceased alive on 8-30, 1949, and that death occurred at 6 05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Charles R. McDonald M.D.	1628 S. Charles St.	8-30-49.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 3 1949	Cedar Hill	Annapolis Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/31/49	A. W. Resnick	John Thenny Inc	715 LIGHT ST -30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07469

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: St. MARGARETS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: St. MARGARETS
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DANIEL	E.	COLLINS	8	31	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M.	W		1895	54 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S. NAVY		ANNAPOLIS, MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES Collins	MARY E. BRACKETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
YES WW I + II		RODOLIE COLLINS (WIFE)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of the rectum

154 46d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4/27/46	Carcinoma of the rectum	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 4/4/46, 19..., to 8/31/49, 19..., that I last saw the deceased alive on 8/31/49, 19..., and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Albert A. Creadon, MD		Annapolis, Md	9/1/49

23. BURIAL, CREMATION, ~~REMOVAL~~ (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	9-3-49	St. MARYS	ANNAPOLIS, MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 3, 1949	[signature]	JOHN M. TAYLOR & SON	ANNAPOLIS MARYLAND

RECEIVED
SEP 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07470

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS in Woods of Ridge Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkridge
STREET ADDRESS (If rural, give location) Race Road

3. NAME OF DECEASED (Type or Print) (First) JAMES (Middle) EDWARD (Last) CRUMBLE
4. DATE OF DEATH (Month) Aug. (Day) 4, (Year) 1949
5. SEX male
6. COLOR OR RACE negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH Feb 8, 1881
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Ditch digging
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME John Crumble
14. MOTHER'S MAIDEN NAME Susie Powell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mollie Gross 5512 Race Rd.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Coronary sclerosis	unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical ADDRESS Examiner, Annapolis Md. DATE SIGNED 8-4-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 8-7-49 NAME OF CEMETERY OR CREMATORY Arbutus Memorial LOCATION (City, town, or county) Arbutus (State) Md.

DATE REC'D BY LOCAL REG. August 6th 1949 REGISTRAR'S SIGNATURE R W D. W. Hedrick 24. FUNERAL DIRECTOR Mrs Kate R. Williams ADDRESS Schroeder St. 3-2-97

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

07471

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lake Shore; MARYLAND; LENGTH OF STAY (in this place) 1 day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Pasadena P.O

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS 3013 (If rural, give location) Windsor Ave.

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) CHARLES (Last) CUMMINGS

4. DATE OF DEATH: (Month) Aug. (Day) 6 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: July 17 1940

9. AGE last birthday: 9 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: James E. Cummings

14. MOTHER'S MAIDEN NAME: Anita Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: James E. Cummings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 183 (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Pub. place (CITY OR TOWN) Lake Shore (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? Drowning

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Beatty (Degree or title) M.D. ADDRESS Deputy Medical Examiner Annapolis Md DATE SIGNED 8-6-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 8-10-49; NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park; LOCATION (City, town, or county) Elkridge (State) Md.

DATE REC'D BY LOCAL REG. 8/9/49; REGISTRAR'S SIGNATURE L. Gerald Hedrick

24. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07472 Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Severna Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days.

Hospital, institution, or street address where death occurred: Cedar Crest Nursing Home

How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County ?

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 207 - S. Broadway (If rural, give LOCATION)

2.(a) If veteran, name war Not Veteran

3. (a) FULL NAME Harry Davis

3. (b) Social Security Number

4. Sex M.

5. Color or race White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) About 1895

8. AGE: Years 54 yrs Months 10 Days If less than one day ..... hrs. ..... min.

9. Birthplace Greece (Town, county, and state)

10. Usual occupation Porter

11. Industry or business Restaurant

FATHER

12. Name George Davis

13. Birthplace Greece

MOTHER

14. Maiden name Helen Paulos

15. Birthplace Greece

16. Informant George Davis (brother)

Address 207 - S. Broadway, Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-16-49 (month) (day) (year)

Cemetery or crematory Greek Cemetery

Location Windsor Mill Rd.

18. Funeral director Lambros Inc.

Address 440 E. North ave

19. 8/15 19 49 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 14 1949 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 11 1949 to Aug. 14 1949 and that I last saw him alive on 8/13/49 19

Immediate cause of death	DURATION
Lobar Pneumonia	4 days
Due to Malnutrition	?
Due to Senility	?
Other conditions	

490 (Include pregnancy within 3 months of death)

108

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave H Pauber M.D. M. D. or other

Address Glen Burnie 6, Md. Date signed 8/14/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07473 26
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Shadyside
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Shady Side
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) John (Middle) H. (Last) Dennis

4. DATE OF DEATH: (Month) Aug. (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Wh

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: April 9, 1883

9. AGE last birthday: 66 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OYSTERMAN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Shadyside. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joshua Dennis

14. MOTHER'S MAIDEN NAME: Mary Jane Griffin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: THOMAS IRA DENNIS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Cerebro-vascular accident

331 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 330 (b):

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) Shadyside (COUNTY) aa (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-18, 1949, to 8-2-, 1949, that I last saw the deceased alive on Aug 2, 1949, and that death occurred at 2:56 P m., from the causes and on the date stated above.

SIGNATURE: A. T. Allen — (Degree or title): M D — ADDRESS: 10 Carroll Annapolis — DATE SIGNED: 8-3-49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: Aug. 5 1949 — NAME OF CEMETERY OR CREMATORY: DENNIS Cemetery — LOCATION (City, town, or county) (State): SHADYSIDE, MD

DATE REC'D BY LOCAL REG.: Aug-3-49 — REGISTRAR'S SIGNATURE: J B. Dent

24. FUNERAL DIRECTOR: J C. Hardesty & Son — ADDRESS: Galesville Md.

RECEIVED
AUG 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 07474

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville, R.F.D. LENGTH OF STAY (In this place) 3 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville R.F.D.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Benfield Road	STREET ADDRESS (If rural, give location) Benfield Road

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) Frances (Last) Dillenbeck

4. DATE OF DEATH (Month) Aug. (Day) 8 (Year) 1949

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH Apr. 23 1872 | 9. AGE last birthday 77 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Chas. Whitney Bates | 14. MOTHER'S MAIDEN NAME Sarah Gourley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. — | 17. INFORMANT Mamie E. Bates

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-vascular disease	unknown
	(c) General Arterio-sclerosis	"

443
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Kaffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 8-8-49

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation | DATE THEREOF 8/10/49 | NAME OF CEMETERY OR CREMATORY Green Mount | LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. 8-9-49 | REGISTRAR'S SIGNATURE L | 24. FUNERAL DIRECTOR Hilliam Cook Inc. 1217 Lt Paul St ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07475

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dudley — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dudley
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Ollie (Middle) (Last) Dorsey

4. DATE OF DEATH: (Month) Aug. (Day) 15 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: May 10 1905

9. AGE last birthday: 44 yrs. — If under 1 year: Months 3, Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): St. Mary Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Dorsey

14. MOTHER'S MAIDEN NAME: Mary Emily

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Gertrude Dorsey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Prostate — Interval between onset and death: 6 mons

177 Antecedent cause(s)

51b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15-49, 19....., to 8-15-49, 19....., that I last saw the deceased alive on 8-15-49, 19....., and that death occurred at 2:55 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Theodore A. Johnson M.D. — ADDRESS 40 Northwest Street — DATE SIGNED August 17, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE Aug. 19 1949 — NAME OF CEMETERY OR CREMATORY: Catholic Cem. — LOCATION (City, town, or county): Owingsville — (State) Md.

DATE REC'D BY LOCAL REG. Aug. 18, 1949 — REGISTRAR'S SIGNATURE D. C. Dent Asst. — 24. FUNERAL DIRECTOR J. B. Johnson — ADDRESS Annapolis

RECEIVED
AUG 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07476

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Severn
LENGTH OF STAY (in this place): 2 Months.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 3121 Virginia Ave. ✓

3. NAME OF DECEASED (Type or Print): Elvin (First) (Middle) Dowell (Last)

4. DATE OF DEATH: Aug (Month) 5 (Day) 1949 (Year)

5. SEX: Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Mar 17, 1876

9. AGE last birthday: 73 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Calvert Co, Md

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | **(If year, give war or dates of service)**:

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: Mrs Helen L Turner.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Arterio-sclerotic Heart Disease — Interval Between Onset and Death: May 1949

241 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Asthma, chronic — 30 Years

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: None.

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐:

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from June, 1949, to Aug 5, 1949, that I last saw the deceased alive on Aug 4, 1949, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE: Edward J Merritt — (Degree or title): M.D — ADDRESS: Sambrills Md — DATE SIGNED: Aug 5, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Aug 9, 1949 — NAME OF CEMETERY OR CREMATORY: Mt Harmony Cem. — LOCATION (City, town, or county) (State): Mt. Harmony Calvert Co. Md

DATE REC'D BY LOCAL REG.: Aug 6, 1949 — REGISTRAR'S SIGNATURE: Grace L. Hutchins / E. Z. Joyce — **24. FUNERAL DIRECTOR** ADDRESS: Wm H. Hutchins, Owings Md.

RECEIVED
AUG 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07477

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville; LENGTH OF STAY (in this place) 18 Years.; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville; STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) Elizabeth (Last) Downs.

4. DATE OF DEATH: (Month) Aug (Day) 17 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: April 20 1865

9. AGE last birthday: 84 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Wood Ward

14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Anderson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: Margaret Helen Sisson (sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — Interval between onset and death: 5 weeks

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

332
838

(b) Generalized Arterio sclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Aug 17, 1949, that I last saw the deceased alive on Aug 16, 1949, and that death occurred at 7:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward J Sherritt M.D. Cambrills Md Aug 17, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE: 8/19/49 | NAME OF CEMETERY OR CREMATORY: Baldwin Memorial | LOCATION (City, town, or county) (State): Millersville, Maryland

DATE REC'D BY LOCAL REG. 8-18-49 | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. | ADDRESS: 1900 Eutaw Place Baltimore, Md.

Mahlon B. Mitchell

07478

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D. #3

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Annapolis
STREET ADDRESS (If rural give location): R.F.D. #3

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Cornelia Johnson Drano
4. DATE OF DEATH (Month) (Day) (Year): Aug. 16 1949
5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)~~
8. DATE OF BIRTH: Nov 24 1896
9. AGE last birthday: 52 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wyoming
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: E. M. Johnson
14. MOTHER'S MAIDEN NAME: Elizabeth Seeman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Col. Charles A. Drano U.S.A. Ret.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 1 day

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Heart Block 1st degree — 1 yr.

93d (c) Myocarditis, Chronic — 1½ yrs.

11. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949, to Aug. 16, 1949, that I last saw the deceased alive on 8-16-, 1949, and that death occurred at 4:00 A.m., from the causes and on the date stated above.

SIGNATURE: James R. Martin, (Degree or title) M.D. — ADDRESS: Annapolis, Md. — DATE SIGNED: 8/16/49

23. ~~BURIAL,~~ CREMATION ~~REMOVAL (Specify)~~ — DATE THEREOF: Aug 17 1949 — NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery — LOCATION (City, town, or county) (State): Prince George Co. Md.

DATE REC'D BY LOCAL REG.: Aug. 17, 1949 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: John M. Taylor Son — ADDRESS: Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 18 1949
BUREAU V. S.

07479

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park — LENGTH OF STAY (in this place) 10 Mos	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Crest Nursing Home	STREET ADDRESS (If rural, give location) 4810 Rithcie Highway

3. NAME OF DECEASED (Type or Print)	(First) Cannie	(Middle)	(Last) Forbes	4. DATE OF DEATH	(Month) Aug. (Day) 5, (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Nov. 8, 1864	9. AGE last birthday 84 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME (Unknown) McGee			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None		17. INFORMANT Mamie Sullenger, 4810 Richie Highway		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	42 hrs.
Antecedent cause(s)	(b) Hypertension	Unknown
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Senility	"

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) NO	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/20, 1949, to 8/4/49, 19....., that I last saw the deceased alive on 8/4/49, 19....., and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave H. Paulsen	M.D.	5 First Ave S.E. Glen Burnie, Md.	8/5/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 8/6/49	NAME OF CEMETERY OR CREMATORY CEDAR ~~Cedar~~ Hill	LOCATION (City, town, or county) (State) Brooklyn, Md
DATE REC'D BY LOCAL REG. Aug 6th 1949	REGISTRAR'S SIGNATURE R.W.	24. FUNERAL DIRECTOR William Cook, Inc., 1217 St. Paul St.	ADDRESS

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

017480

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jones Station; STREET ADDRESS (If rural, give location) Ritchie Highway

3. NAME OF DECEASED (Type or Print): (First) John (Middle) A. (Last) Fox

4. DATE OF DEATH: (Month) August (Day) 25 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: March 23, 1872

9. AGE last birthday: 77 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior Decorator

10b. KIND OF BUSINESS OR INDUSTRY: Interior Decorator

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John A. Fox

14. MOTHER'S MAIDEN NAME: Christina Geum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs John Amoss

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic vascular disease — —

83a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 8

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/24/49, 19..., to 8/25, 19..., that I last saw the deceased alive on 8/25, 19..., and that death occurred at 1:25 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Manuel Klaveris, MD Annapolis, Md 8/27/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 8-27-49 | NAME OF CEMETERY OR CREMATORY Glen Haven | LOCATION (City, town, or county) Glen Burnie, (State) Md.

DATE REC'D BY LOCAL REG. Aug. 27, 1949 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John B. Taylor & Son ADDRESS Annapolis, Md.

RECEIVED
AUG 31 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07481 21

1. PLACE OF DEATH: COUNTY a a MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 36 Hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) (Last) Gibson
4. DATE OF DEATH (Month) aug (Day) 4 (Year) 1949
5. SEX X
6. COLOR OR RACE w
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 8/3/49
9. AGE last birthday yrs. If under 1 year Months 36 hrs. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Russell H Gibson
14. MOTHER'S MAIDEN NAME Anne Pearl Crandall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Russell H Gibson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Monstrosity (Head deformity)

750 Antecedent cause(s)

157 d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Monstrosity (Head deformity)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3/49, 19....., to 8/4/49 19....., that I last saw the deceased alive on 8/4, 1949, and that death occurred at 1:21 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Albert F. Anderson MD ADDRESS 2,445 Santa Rosa DATE SIGNED Annapolis Md. 8/4/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Aug 5/49
NAME OF CEMETERY OR CREMATORY Friendship
LOCATION (City, town, or county) Friendship (State) Md
DATE REC'D BY LOCAL REG. Aug. 5, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR W H Hutchins & Son
ADDRESS Owens Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07482

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY A. A. — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Prince Leo St.

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) L. (Last) Golden R.

4. DATE OF DEATH: (Month) 8 (Day) 13 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 4-19-1865

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Golden

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. J. Wallis Martin Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Prostate — 12-18 Mo.

177 5th Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Hemorrhage (or Metastasis) — 1-2 Mos.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/4, 19 49, to 8/13, 19 49, that I last saw the deceased alive on 8/12, 19 49, and that death occurred at 7:55 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Mannie Klevans, Md — Annapolis, Md — 8/15/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF 8-15-49 | NAME OF CEMETERY OR CREMATORY St Annes | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Aug. 15, 1949 | REGISTRAR'S SIGNATURE W. J. Lynch | 24. FUNERAL DIRECTOR John M. Taylor Son — ADDRESS Annapolis Md.

VS. A15

RECEIVED
AUG 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07483

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Beatrice (Middle) (Last) Green

4. DATE OF DEATH (Month) Aug. (Day) 18 (Year) 1949

5. SEX Female
6. COLOR OR RACE Col
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)
8. DATE OF BIRTH Sept 1 1905
9. AGE last birthday 43 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY House work
11. BIRTHPLACE (State or foreign country) A.A. Co Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ~~Henry Downs~~ Benj. Butler
14. MOTHER'S MAIDEN NAME Mary Brent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. ✓
17. INFORMANT AND ADDRESS Mary V. Randall Cumberstone Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) acute heart failure

023 Antecedent cause(s)

30d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) syphilitic aortitis, mitral insufficiency

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 13, 1949, to Aug. 18, 1949, that I last saw the deceased alive on Aug 17, 1949 and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Emily H. Wilson, M.D. ADDRESS Lothian, Md. DATE SIGNED 8/18/49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE AUG. 21, 1949
NAME OF CEMETERY OR CREMATORY Crownsville Cem.
LOCATION (City, town, or county) Galesville. (State) Md

DATE REC'D BY LOCAL REG. Aug 21st 1949
REGISTRAR'S SIGNATURE M. Clayton Dep Local Reg
24. FUNERAL DIRECTOR T.A. Hardesty & Son ADDRESS Galesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07484

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Creek, Pasadena P.O. LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort Smallwood Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P.O.
STREET ADDRESS (If rural, give location) Fort Smallwood Road.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) LEE (Last) GREISER
4. DATE OF DEATH: (Month) AUG. (Day) 29 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: July 9, 1944
9. AGE last birthday: 5 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edward W. Geiser
14. MOTHER'S MAIDEN NAME: Rosalie Thompson.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robert Gibson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accident

183 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home at Creek (CITY OR TOWN) Pasadena P.O. (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 29 1949 4.45 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Was fishing from bridge and fell into Creek

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Claffey M.D. Deputy Medical Examiner Annapolis Md 8/29/49

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL. DATE THEREOF 9/2/49 NAME OF CEMETERY OR CREMATORY Loudon Park LOCATION (City, town, or county) (State) Baltimore Maryland

DATE REC'D BY LOCAL REG. 8/31/49 REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR John F. Denny, Inc ADDRESS Frederick Road 715 Light St.

-30

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07485

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Annapolis
STREET ADDRESS (If rural, give location) RFD Box 95 Annapolis, Md.

3. NAME OF DECEASED (Type or Print) (First) Catherine (Middle) Baby Bugle (Last) Girt Harrison

4. DATE OF DEATH (Month) August (Day) 8 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 8-8-1949
9. AGE last birthday yrs. If under 1 year Months. Days If under 24 hrs. Hours 1 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William P. Harrison, Jr.
14. MOTHER'S MAIDEN NAME Emma Rebecca Beegle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Wm. P. Harrison

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity

761.5 Antecedent cause(s)

160c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Premature Separation Placenta

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above:

SIGNATURE [signature] (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 8/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Aug. 9, 1949
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Aug. 9, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Layton & Son
ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07486

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Severn
LENGTH OF STAY (in this place) 53 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) LAWRENCE (Middle) WESLEY (Last) HOOD
4. DATE OF DEATH: (Month) AUG (Day) 18 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: July 3 1916
9. AGE last birthday: 33 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assembler Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Mfg- Truck Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Hood
14. MOTHER'S MAIDEN NAME: Anna Busey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-03-1912
17. INFORMANT: Mrs Dora Mae Hood Severn, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) SUICIDE	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) bullet .22 cal. semi-automatic rifle wound	
	(c)	

976 16 1 c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: at home | (CITY OR TOWN) Severn | (COUNTY) A.A. | (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 18, 1949 6 P.m. | INJURY OCCURRED While at work ☐ Not while at work ☑ | HOW DID INJURY OCCUR? Self inflicted wound in right temple

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy (Degree or title) M.D., ADDRESS Deputy Medical Examiner, Annapolis Md. DATE SIGNED 8-18-49.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 8/21/49 | NAME OF CEMETERY OR CREMATORY: Friendship Cem. A. A. Co. | LOCATION (City, town, or county) (State): A. A. County, Md.

DATE REC'D BY LOCAL REG.: Aug. 20th 1949 | REGISTRAR'S SIGNATURE: R.W.

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS INC. ADDRESS: North & Pa. Baltimore 17

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07487

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D. | LENGTH OF STAY (in this place) 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eppug Forest

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1832 D N.E. Apt. #1

3. NAME OF DECEASED (Type or Print): (First) DAVID (Middle) WESSON (Last) HOWELL

4. DATE OF DEATH: (Month) Aug. (Day) 6 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH: Sept. 6, 1907 | 9. AGE last birthday: 41 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk | 10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt. | 11. BIRTHPLACE (State or foreign country): Kentucky | 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William Terry Howell | 14. MOTHER'S MAIDEN NAME: Mary Wesson [redacted]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. Caroline E. Howell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — Sudden
420.1
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — unknown
94a
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
John M. Caffey M.D., Deputy Medical Examiner | Annapolis Md | 8-6-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Aug 8-49 | NAME OF CEMETERY OR CREMATORY Cedar Hill | LOCATION (City, town, or county) Prince Geo. Co. | (State) Md.

DATE REC'D BY LOCAL REG. Aug. 6, 1949 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR The S. E. Hines Co. | ADDRESS 2901 14th St. N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07488

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 12hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 15
STREET ADDRESS (If rural, give location): 6945 Reistertown Road

3. NAME OF DECEASED (Type or Print): (First) John (Middle) "B" (Last) JAMISON

4. DATE OF DEATH: (Month) August (Day) 27 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Newborn

8. DATE OF BIRTH: August 27, 1949

9. AGE last birthday: ___ yrs. If under 1 year: Months ___ Days ___ If under 24 hrs.: Hours 12 Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): U.S.N.H., Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James P. JAMISON LCDR, USN

14. MOTHER'S MAIDEN NAME: Ruth Holden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service) ___

16. SOCIAL SECURITY NO. ___

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) PREMATURITY, (5½ months pregnancy)

776 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

159 (b) None

(c) None

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ___

19b. MAJOR FINDINGS OF OPERATION ___

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 27, 1949, to August 27, 1949, that I last saw the deceased alive on August 27, 1949, and that death occurred at 11:55 P m., from the causes and on the date stated above.

SIGNATURE: J. W. Miller (Degree or title) CAPTAIN, MC, USN ADDRESS U.S. Naval Hospital, Annapolis, Md. DATE SIGNED 8-29-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 8-29-49
NAME OF CEMETERY OR CREMATORY: NAVAL CEMETERY
LOCATION (City, town, or county) (State): ANNAPOLIS

DATE REC'D BY LOCAL REG.: Aug 29, 1949
REGISTRAR'S SIGNATURE: W. O. Branch

24. FUNERAL DIRECTOR: P.L. HOPPING & SON ADDRESS: ANNAPOLIS, Md.

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AUG 31 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07489

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Pasadena P.O. Md. — LENGTH OF STAY (in this place): 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: none

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural, Pasadena P.O., Md.
STREET ADDRESS (If rural give location): off Ft. Smallwood Road.

3. NAME OF DECEASED (Type or Print): (First) Pearl (Middle) none (Last) Jasper

4. DATE OF DEATH: (Month) Aug. (Day) 19 (Year) 1949

5. SEX: female

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: ~~Sept.~~ 22, 1922

9. AGE last birthday: 26 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Albert Jasper

14. MOTHER'S MAIDEN NAME: Rebeccah Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: Mrs. Rebeccah Jones.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) inanition

5723 / 1260 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic diarrhea, etiology unknown — Dec. 1948

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? none.

22. I hereby certify that I attended the deceased from June 15, 19 49, to Aug. 19, 19 49, that I last saw the deceased alive on Aug. 18, 19 49, and that death occurred at 9:00 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Randall M. McLaughlin, M.D. — Pasadena P.O., Md. — Aug. 19, 1949

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE THEREOF: 8-21-49 — NAME OF CEMETERY OR CREMATORY: MAGOTHY — LOCATION (City, town, or county) (State): ANNE ARUNDEL Co. MD.

DATE REC'D BY LOCAL REG.: 8/20 — REGISTRAR'S SIGNATURE: L. J. Dr Alba

24. FUNERAL DIRECTOR — ADDRESS: Wm. A. JACKSON - 916 PENNA. AVE., BALTIMORE 1, MD.

RECEIVED
AUG 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07490

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mulberry Hill | LENGTH OF STAY (In this place) 61 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. #2 Annapolis Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis Md. R.F.D. #2.
STREET ADDRESS (If rural, give location) Mulberry Hill

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HARRISON	ELIJAH	JOHNSON	Aug.	16	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	negro	married	Aug. 12 1888	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	U.S.N. Exp. Sta	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of	16. SOCIAL SECURITY NO.	17. INFORMANT
ELIJAH JOHNSON	Harriett Ireland.	World Wars I and II	—	Grafton Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Drowning	sudden
172 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Accidental	"
	(c) Coronary Thrombosis.	while in boat before drowning occurred
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY Mill Creek	(CITY OR TOWN) near Annapolis	(COUNTY) A.A.	(STATE) Md
TIME (Month) (Day) (Year) (Hour) OF INJURY Aug. 16, 1949 9:40 a.m.	INJURY OCCURRED While at work ☐ Not while at work ☑	HOW DID INJURY OCCUR? Was crabbing in row-boat and fell overboard		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Caffey M.D.,	Deputy Medical Examiner,	Annapolis Md	8-16-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 19 1949	Broadneck	St. Margaretta

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 19, 1949	[illegible]	J. B. Johnson	Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07491

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 105 W. Hilltop Rd.	STREET ADDRESS (If rural, give location): 105 W. Hilltop Rd.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	P	Kubenik	Aug.	16,	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	Widowed	Sept. 16 1862	86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	--	Czechoslovakia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Suchanik	Pauline ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Mrs. Caroline C. Koehnle 105 W. Hilltop Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) coronary occlusion

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (b) hypertensive cardiovascular disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug., 1946, to Aug 16 1949, that I last saw the deceased alive on Aug 16, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Philip A. Kuister, M.D		302 Patapsco Ave	Aug. 17 '49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/18/49	Holy Redeemer	Baltimore Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/17/49	[signature]	WM. J. TICKNER & SONS INC.	North Ave. Balto. 17, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

017492

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 18 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 47 Smithville Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 47 Smithville Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harriet	Ann	Lane	8	4	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Col	Widowed	1-26-61	88 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook		Prince George Co.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Toolgood	Anne Dobson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Mary Clay

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Failure	2 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	2 days
443 93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3, 1949, to 8/4, 1949, that I last saw the deceased alive on 8/3, 1949, and that death occurred at 5:51 A.M., from the causes and on the date stated above.

SIGNATURE Theodore L. Thomas M.D. (Degree or title) ADDRESS 46 Northwest Street DATE SIGNED 8/6/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-9-49	Brewer Hill	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 7, 1949	[signature]	Wm. Chas. A. Hicks & Son	

VS. A15

RECEIVED
AUG 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07493

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carvel Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carvel Beach
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Rose (Middle) A (Last) Lamont

4. DATE OF DEATH: (Month) Aug (Day) 4 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 13 1872

9. AGE last birthday: 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown Davidson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Frank K Lamont, Carvel Beach Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) coronary occlusion

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic cardiovascular disease

93d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 4, 1949, to Aug 4, 1949, that I last saw the deceased alive on Aug 4, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Philip W. Kessler MD — ADDRESS 302 Patapsco Av — DATE SIGNED Aug 5 49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE 8/6/49. — NAME OF CEMETERY OR CREMATORY London Park — LOCATION (City, town, or county) Baltimore (State) Md

DATE RECD BY LOCAL REG. August 6 1949 — REGISTRAR'S SIGNATURE R W D W Fedrick

24. FUNERAL DIRECTOR — ADDRESS Mathorn & Son 1217 Eutaw St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1a 07523

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft Geo G Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 hrs. 30 min.

Hospital, institution, or street address where death occurred:
Sta Hosp., Ft Meade, Md.

How long in hospital or institution? 11 hrs. 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto. Co.

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edgewater Apts #3
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Baby Boy Leavenworth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	N/A

6.(b) Name of husband or wife: Charles B Leavenworth
Barbara E Leavenworth

6.(c) If alive, give age: 0 years

7. Birth date of deceased (mo., day, yr.): 19 August 1949

8. AGE:

Years	Months	Days	If less than one day
			11 hrs. 30 min.

9. Birthplace: Ft. Geo. G. Meade, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Charles B. Leavenworth
13. Birthplace: Rochester, New York

MOTHER
14. Maiden name: Barbara Elaine Schmid
15. Birthplace: London, England

18. Informant: —
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 22 Aug 1949 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Ft. Geo. G. Meade, Md.

18. Funeral director: Chap. John E. Batterson

Address: Ft. Geo G Meade, Md.

19. 20 Aug. 19 49 (Date rec'd by registrar) E K Burnside Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 Aug 19 at 11 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19 Aug 19 49

Immediate cause of death: Fetal Atelectasis
Possible Intracranial Hemorrhage — DURATION

Due to:

Due to:

Other conditions: Prolonged Labor

760.0
161.0
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W Mitchener Jr M. D. or other

Address: Ft. Meade Date signed: 19 Aug

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 05 1940
BUREAU V. S.

07494

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Meade
LENGTH OF STAY (In this place) 8 2 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort Geo G. Meade Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Meadedale, Odenton, P.O.,
STREET ADDRESS (If rural, give location) 4 Lambert Road

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) FRANK THEODORE LOANE
4. DATE OF DEATH (Month) (Day) (Year) Aug. 16 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 7. 1894
9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto upholsterer
10b. KIND OF BUSINESS OR INDUSTRY Automobile
11. BIRTHPLACE (State or foreign country) Baltimore - Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Frank Loane
14. MOTHER'S MAIDEN NAME Louise Denhardt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Notch Part
16. SOCIAL SECURITY No. 216-05-6938
17. INFORMANT Charles Loane

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Accident	sudden
443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular-hypertensive	unknown
93d	(c) arterio-sclerosis	12 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D., (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 8-16-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/19/49
NAME OF CEMETERY OR CREMATORY National
LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. 8/17/49
REGISTRAR'S SIGNATURE Arv. Hedrick Dr
24. FUNERAL DIRECTOR Wilhoom Cook Inc 1217 St Paul St ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07495

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Carroll Creek Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Helen Nina Mac Pherson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Donald Mac Pherson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 18. 1874

8. AGE: Years	Months	Days	If less than one day
75	5	29	..... hrs. ..... min.

9. Birthplace Hungary (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name Binay
13. Birthplace Hungary

MOTHER
14. Maiden name Paulina P
15. Birthplace Hungary

16. Informant Pauline I. Maltby
Address Carroll Creek Road. Riviera Beach

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 19-1949 (month) (day) (year)
Cemetery or crematory
Location White Plains. New York
18. Funeral director Mr. & Mrs. John W. Teufel & Son
Address 5311 Edmondson Ave.

19. 8/17 (Date rec'd by registrar) 19 49 D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1949, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1949, to Aug 16 1949
and that I last saw her alive on Aug 16 1949

Immediate cause of death	Duration
Coronary Occlusion	sudden
Due to Chronic myo-cardetis	
Due to	
Due to	
Other conditions	

420.1
93d

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos. H. Phillips M.D.
M. D. or other
Address 3307 Edmondson Date signed 8-16-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Allen

07496

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M The correct age

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS-A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Phoebe (Middle) (Last) Matthews

4. DATE OF DEATH: (Month) Aug. (Day) 19 (Year) 1949

5. SEX: Female | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow | 8. DATE OF BIRTH: 1884 | 9. AGE last birthday: 65 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): A. A. Co. Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nelson Stebbenson | 14. MOTHER'S MAIDEN NAME: Louise Stepney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Nellie Clopton, 519 W. Bond Baltimore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Lung Abcess

Antecedent cause(s)

521 / 114d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-21, 19 49, to 8-19, 19 49, that I last saw the deceased alive on 8-17, 19 49, and that death occurred at 3.30 P. m., from the causes and on the date stated above.

SIGNATURE G. T. Allen (Degree or title) MD | ADDRESS 10 Carroll | DATE SIGNED 8-22-49

23. BURIAL, CREMATION REMOVAL (Specify) | DATE Aug. 23 1949 | NAME OF CEMETERY OR CREMATORY Broadneck | LOCATION (City, town, or county) St Margarets (State) Md.

DATE REC'D BY LOCAL REG. Aug. 23, 1949 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis

RECEIVED
AUG 26 1949
BUREAU T. S.

07497

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) D.O.A
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 2702 - 30th St. S.E.

3. NAME OF DECEASED (Type or Print) (First) CLAUDE (Middle) L. (Last) METCALF
4. DATE OF DEATH (Month) Aug. (Day) 7, (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 10, 1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer
10b. KIND OF BUSINESS OR INDUSTRY Power Co
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John A. Metcalf
14. MOTHER'S MAIDEN NAME Susie Brausdetter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Robert T. Thompson Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary occlusion	sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary sclerosis	unknown
94a (c)	Arterial hypertension	about 2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D., (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 8-7-49

23. ~~BURIAL~~, CREMATION, REMOVAL ~~(Specify)~~ DATE THEREOF Aug 7, 1949 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. Aug. 7, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR Deal Funeral Home ADDRESS Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 9 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07498

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural — LENGTH OF STAY (in this place) 18 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Huntingtan
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Gourley (Middle) (Last) Morsell

4. DATE OF DEATH: (Month) August (Day) 20 (Year) 1949

5. SEX: male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: 1914

9. AGE last birthday: 35 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Garry Morsell

14. MOTHER'S MAIDEN NAME: Edmonie Morsell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Crownsville State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) advanced pulmonary tuberculosis — unknown

002 Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Congenital Idiot

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Febr. 6, 1948 to August 20, 1949, that I last saw the deceased alive on August 20, 1949, and that death occurred at 2.10 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Jacob Marquardt M.D. — ADDRESS Crownsville Md — DATE SIGNED 8/21/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE Aug 23, 1949 — NAME OF CEMETERY OR CREMATORY Plumpoint, C. — LOCATION (City, town, or county) Calvert Cty (State) Md

DATE REC'D BY LOCAL REG. 8-21-49 — REGISTRAR'S SIGNATURE E. F. Joyce Local Reg.

24. FUNERAL DIRECTOR: P. G. Sewell — ADDRESS Prince Frederick Cty, Md

RECEIVED
AUG 24 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07499

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town Ft George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 hours.

Hospital, institution, or street address where death occurred:
Sta Hosp. Ft George G. Meade,

How long in hospital or institution? 43 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore Co.

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1124 Stephen Drive
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME
SHARON MARIE O'CONNELL

3. (b) Social Security Number
—

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2 Aug 49

8. AGE:

Years	Months	Days	If less than one day
0	0	1 3/4	..... hrs. ..... min.

9. Birthplace Ft G.G. Meade, ANNE ARUNDEL, Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business —

FATHER
12. Name FRANK J. O'CONNELL
13. Birthplace Redding, Pa

MOTHER
14. Maiden name Maxine NMI Armstrong
15. Birthplace Tulsa Oklahoma

16. Informant FRANK J. O'CONNELL
Address 39TH CID, FT. MEADE, MD.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof August 5 1949
(month) (day) (year)

Cemetery or crematory Post Cemetery

Location Fort George G. Meade, Maryland

18. Funeral director Capt J. T. Hayes Chaplain
Address Fort George G. Meade, Maryland

19. 4 August 1949
(Date rec'd by registrar)
E.K. Burnside
E.K. BURNSIDE, Capt, MSC
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Aug 1949 at 1020 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Aug 1949 to 4 Aug 1949 and that I last saw her alive on 4 Aug 1949

Immediate cause of death CARDIO-RESPIRATORY COLLAPSE

Due to Prematurity

Due to

Other conditions
776
159
(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Shannon Jr. M.D.
FRANK J. SHANNON JR. Capt., M.D. or other

Address Sta Hosp Ft G.G. Meade Md Date signed 4 Aug 49

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07500

Reg. Dist. No. 21

1. PLACE OF DEATH: AA

County

City or town: Edgewater, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A

City or town: Edgewater, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Edgewater Drive & Ridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: **********

3.(a) FULL NAME: Sarah E. Orem

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John H. Orem

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 17, 1863.

8. AGE: Years	Months	Days	If less than one day
85	10	13	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: John T. Kauffmann

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah A. Bond

15. Birthplace: Maryland

18. Informant: Mrs. Nell Coursen

Address: Edgewater, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1949 (month) (day) (year)

Cemetery or crematory: Lorraine

Location: Woodlawn, Md.

18. Funeral director: H. W. Mears & Son

Address: 805 N. Calvert St., Balto. Md.

19. 8/31/49 (Date rec'd by registrar) L.J. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 30 1949, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1940, to Aug 30 1949 and that I last saw h[illegible] alive on Aug 29 1949

Immediate cause of death	DURATION
Myocarditis Chr with Myocardial Insufficiency	8 yrs
Due to Arteriosclerosis	2 years
Due to Senility	
Other conditions Hypertension 443 93d	8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo C Boyd M. D. or other

Address: Annapolis Md. Date signed: 8-30-49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Johnson

07501

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian | LENGTH OF STAY (In this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) (Last) Parker

4. DATE OF DEATH: (Month) Aug. (Day) 3 (Year) 49

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH May 16 1878 | 9. AGE last birthday 71 yrs. If under 1 year: Months 2, Days, If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) A. A. Co. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Parker | 14. MOTHER'S MAIDEN NAME Georgana Powell.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Richard Parker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure — 7-19-49

443 Antecedent cause(s)

930 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular Disease — 8-3-49

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-19-49, 19..., to 8-3-49, 19..., that I last saw the deceased alive on 8-3-49, 19..., and that death occurred at 8.30 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Geraldine H. Johnson M.D. 40 Northwest Street Annapolis, Md.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Aug. 7 1949 | NAME OF CEMETERY OR CREMATORY Adams | LOCATION (City, town, or county) Lothian | (State) Md.

DATE REC'D BY LOCAL REG. Aug. 5, 1949 | REGISTRAR'S SIGNATURE W. R. Clayton Dep. Asst. | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis

RECEIVED
AUG 8 1949
BUREAU V. S.

07502

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: A.A.
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 206 Arundel Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GRACE M. PHIPPS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Vernon H.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): I/13/1889

8. AGE: Years	Months	Days	If less than one day
60	7	6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: John S. Parks
13. Birthplace: Del.

MOTHER
14. Maiden name: Josephine Edgar
15. Birthplace: Md.

16. Interment: Family
Address: Same

17. B (Burial, cremation, or removal. Which?) Date thereof: 8/22/49 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie
18. Funeral director: James L. DeCarlo
Address: 130 E. Fort Ave.

19. August 21 1949 (Date rec'd by registrar) Ida M. Whitman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1949 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 19 1949 and that I last saw her alive on Aug 19 1949

	DURATION
Immediate cause of death: coronary occlusion	
Due to: hypertensive cardio-vascular disease	
Due to:	
Other conditions: chronic bronchial asthma 493.1	

(Include pregnancy within 3 months of death)
93d

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Philip W. Keister, MD M. D. or other
Address: 302 Pathway Ave Date signed: Aug 21 '49

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 21 1949
BUREAU V. S.

M

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07503

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred: Cedar Crest Nursing Home

How long in hospital or institution? 11 month

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Galesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert Salem Price

3. (b) Social Security Number: none

4. Sex: M.

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 2 1888

8. AGE: Years: 61 Months: 5 Days: 11 If less than one day ... hrs. ... min.

9. Birthplace: Galesville, A. A. County, Md. (Town, county, and state)

10. Usual occupation: Saw Mill

11. Industry or business

FATHER

12. Name: Robert Price

13. Birthplace: Sudley Md

MOTHER

14. Maiden name: Emma L. Avery

15. Birthplace: Shadyside, Md

16. Informant: Harold Price

Address: Sudley Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 15 1949 (month) (day) (year)

Cemetery or cremetory: Tucker

Location: Galesville Md

18. Funeral director: T. A. Hardisty & Son

Address: Galesville Md.

19. Aug 15 1949 (Date rec'd by registrar) L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13 19 ... at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1948 to Aug. 12 1949 and that I last saw him alive on Aug. 12 19

Immediate cause of death: Chronic Myocarditis — Duration: 11 months

Due to: Deformans arthritis — ?

Due to:

Other conditions: 723.0 (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Gustave H. Faucher M.D. M. D. or other

Address: Glen Burnie Md. Date signed: 8/14/49

RECEIVED
AUG 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07504

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills
HOSPITAL OR INSTITUTION OR STREET ADDRESS: RFD #1	STREET ADDRESS (If rural give location): RFD #1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Margaret	May	Purdham	8-30-	49	19

6. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMale	White	dowed	Oct. 2, 1879	69 yrs.	8	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Chris Snyder	Victoria Southers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		James L. Purdham

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

462.1 / 100a

Immediate cause (a) Hemorrhage — Interval between onset and death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Esophageal varix rupture — Interval between onset and death: sudden

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug. 1, 19 49, to Aug. 28, 19 49, that I last saw the deceased alive on Aug. 28, 19 49, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Caffey	M.D.	98 Gloucester St Annapolis, Md.	9/2/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 3, 49	Glen Haven Cemetery	Glen Burnie, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/2-49	E. F. Joyce L. R.	B.L. Hopping and Son	Annapolis, Md.

RECEIVED
SEP 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 52 07505

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena P.O. — LENGTH OF STAY (in this place): unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Ventnor Road, Lake Shore

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1975 West Lexington

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) LEWIS (Last) PURDUM

4. DATE OF DEATH: (Month) Aug. (Day) 27. (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/27/09

9. AGE last birthday: 40 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY: Auto Dealer

11. BIRTHPLACE (State or foreign country): Montgomery Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Spencer R. Purdum

14. MOTHER'S MAIDEN NAME: Beulah L. Mullican

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: 218-07-5955

17. INFORMANT: Mrs. Alice N. Purdum - 1925 W. LexingtonSt.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

973.1 **Immediate cause** (a) Carbon monoxide poisoning

1631 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Suicide

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY: Ventnor Road | (CITY OR TOWN) Lake Shore Pasadena P.O. (COUNTY) A.A. (STATE) Md

TIME (Month) (Day) (Year) (Hour) OF INJURY: not Known m. | INJURY OCCURRED While at work ☐ Not while at work ☑ | HOW DID INJURY Ooccur? closed all windows except one, attached rubber hose to exhaust of auto and got into car

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy (Degree or title) M.D. Deputy Medical Examiner ADDRESS: Annapolis Md DATE SIGNED: 8-27-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 9/30/49 | NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem. | LOCATION (City, town, or county) (State): Balto., Md.

DATE RECD BY LOCAL REG.: 8/29/49 | REGISTRAR'S SIGNATURE: Ada Hedrick

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS. A15A

07506

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton
LENGTH OF STAY (In this place): 24 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Bucklnia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton P.O
STREET ADDRESS (If rural, give location): Bucklnia Ave. Mayfield

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) ROBERT (Last) REIGLE
4. DATE OF DEATH: (Month) Aug. (Day) 14 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: June 10, 1947
9. AGE last birthday: 2 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13. FATHER'S NAME: Howard Reigle
14. MOTHER'S MAIDEN NAME: Beatrice Perkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Howard Reigle

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Shot-gun Wound of Head — sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Accidental
919.0
184
(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: brother pointed shot-gun at him and blew head almost off

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: at home
(CITY OR TOWN): Odenton (COUNTY): A A (STATE): Md
TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 14, 1949 11 A m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Brother 6 years old did not know Gun was loaded

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Cathy M.D. (Degree or title): Deputy Medical Examiner ADDRESS: Annapolis Md DATE SIGNED: 8-14-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Aug 17, 1949
NAME OF CEMETERY OR CREMATORY: Epiphony
LOCATION (City, town, or county): Odenton (State): Md

DATE REC'D BY LOCAL REG.: 8/17/49
REGISTRAR'S SIGNATURE: L. J. DeAlba
24. FUNERAL DIRECTOR: Thomas W. Singleton, Glen Burnie ADDRESS:

VS-A15A

RECEIVED
AUG 18 1949
BUREAU V. S.

Evidence for change of age shown on:

FILM No. G 121 SEP -6 1949

07507

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
LENGTH OF STAY (in this place) 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 140

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY Allegheny
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pittsburg.
STREET ADDRESS (If rural, give location) 604 California ave.

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) M. (Last) Reimer

4. DATE OF DEATH (Month) Aug. (Day) 30 (Year) 1949

5. SEX F.
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 8/10/83
9. AGE last birthday 65-66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Alsace Lorraine - France
12. CITIZEN OF WHAT COUNTRY? U.S. Citizen

13. FATHER'S NAME Kaspar LAST HAESSLER
14. MOTHER'S MAIDEN NAME Virginia Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Mr. Lewis W. Reimer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Occlusion	sudden.
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave D. Pauber (Degree or title) MD. ADDRESS Glen Burnie, Md. DATE SIGNED 8/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 3, 1949
NAME OF CEMETERY OR CREMATORY North Side Catholic
LOCATION (City, town, or county) (State) Westview, Allegheny, Pa.

DATE REC'D BY LOCAL REG. 8/31/49
REGISTRAR'S SIGNATURE Dr Alba L. J.
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1

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RECEIVED
SEP 2 1949
BUREAU V. S.

Evidence for change of birth date and age shown on

STATE OF MARYLAND—CERTIFICATE OF DEATH

07508

LOCAL NO. 6 12 SEP 16 1949

1. PLACE OF DEATH

County E. G. Registration Dist. No.

Village or City Glen Burnie No. 2 Severn Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Agnes G. Rosilek

(a) Residence: No. 2418 E. Monument St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph H. Rosilek

6. DATE OF BIRTH (month, day, and year): Dec 29, 1892

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52	56	7	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Hair Dresser

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Self

10. Date deceased last worked at this occupation (month and year): June 1949

11. Total time (years) spent in this occupation: 22 yr

12. BIRTHPLACE (city or town) (State or country): Bohemia

FATHER

13. NAME: Vaclav Zahradka

14. BIRTHPLACE (city or town) (State or country): Bohemia

MOTHER

15. MAIDEN NAME: Centonie Baroch

16. BIRTHPLACE (city or town) (State or country): Bohemia

17. INFORMANT (Address): Joseph H. Rosilek 2418 E. Monument

18. BURIAL, CREMATION, OR REMOVAL

Place: Holy Redeemer Date: Aug 29, 1949

19. UNDERTAKER (Address): Wade Evans Funeral Home 200 E. Chase St.

20. FILED: 8/26, 19 49 A. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug 25 (Month) (Day), 1949 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 4, 1949, to Aug 25, 1949

I last saw h.. alive on Aug 23, 1949; death is said to have occurred on the date steted above, at ... m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Gall Bladder	?

Other Contributory Causes of Importance:

155

46f

Name of oparation ... Date of ...

What test confirmed diagnosis? ... Was there an au'opsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of Injury ...

Neture of injury ...

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) Joseph P. Kerney M. D.

(Address) 2200 E. Madison St

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07509

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Anne Arundel Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold P.O.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ceylon Park

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 333 E. 22nd St.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Cecilia (Last) Russell

4. DATE OF DEATH (Month) Aug. (Day) 2nd (Year) 1949

5. SEX Female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH Oct. 29, 1879 | 9. AGE last birthday 70 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas P. Lambdin
14. MOTHER'S MAIDEN NAME Mary F. Barranger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Cecil H. Russell Severna Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary thrombosis	2 days
420.1 Antecedent cause(s)		
940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary heart disease	
	(c) previously treated by Dr. H. Klaveans Annapolis Md	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 2nd, 1949, to Aug. 2nd, 1949, that ~~I~~ Dr. Klaveans last saw the deceased alive on Aug. 1st, 1949, and that death occurred at 4.55 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Edith Rodler M.D. 42 State Circle Annapolis 8-3-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 8/5/49 | NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REG. 8/4/49 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS WM. J. TICKNER & SONS Balto., Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07510

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 1011 Smithville St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Pedro	E.	Santos	August	30	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Colored	Married	Dec. 2, 1879	69 yrs.	8	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook		Portugal	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Annabell Santos

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Lung

163 Antecedent cause(s)

47d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-16-49 to 8-30-49, that I last saw the deceased alive on 8-25-49, and that death occurred at 9:10 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. T. Allen	M.D.	18 Carroll	8-31-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Sept. 2, 1949	St. Mary's Cemetery	Annapolis,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 2, 1949	Wm. J. French	J. B. Johnson	Annapolis Md P.O. Box 662

RECEIVED
SEP 5 1949
BUREAU T. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07511

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 107 Oak Ave.	STREET ADDRESS (If rural, give location) 107 Oak Ave.

3. NAME OF DECEASED (Type or Print)	(First) EARL	(Middle) B.	(Last) SCHOFIELD	4. DATE OF DEATH	(Month) Aug. (Day) 12, (Year) 1949
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Mar. 1, 1895	9. AGE last birthday 54 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman	10b. KIND OF BUSINESS OR INDUSTRY Mimeographing	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Henry B. Schofield		14. MOTHER'S MAIDEN NAME Carrie L. Engler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 216-03-8906	17. INFORMANT Mrs. Sara E. Schofield - 107 Oak Ave.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
154	Immediate cause	(a) Carcinoma of the Rectum	1 year
46d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) —	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION Aug 1948	19b. MAJOR FINDINGS OF OPERATION Carcinoma of Rectum & Sigmoid.	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) no	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) —	(COUNTY) —	(STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐ —	HOW DID INJURY OCCUR? —		

22. I hereby certify that I attended the deceased from Aug., 1948, to Aug., 1949, that I last saw the deceased alive on Aug 11, 1949, and that death occurred at 9 a. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James S. Bellingolia M.D.		108 Central Ave Glen Burnie. Md	Aug. 13, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 8/15/49	NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	LOCATION (City, town, or county) (State) Pikesville, Md.
DATE REC'D BY LOCAL REG. Aug 13th 1949	REGISTRAR'S SIGNATURE R. W. P. Hedrick	24. FUNERAL DIRECTOR WM. J. TICKNER & SONS	ADDRESS Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

97512

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side
LENGTH OF STAY (in this place) all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Scott-Town

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side
STREET ADDRESS (If rural, give location) Scott-Town

3. NAME OF DECEASED (Type or Print): (First) BRITTON (Middle) H. (Last) SCOTT
4. DATE OF DEATH: (Month) Aug. (Day) 2 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married
8. DATE OF BIRTH: Feb 26, 1874
9. AGE last birthday: 75 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Shady Side, Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Jacob Scott
14. MOTHER'S MAIDEN NAME: Matilda (not known)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT: Gladys. Gross

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Failure	sudden
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Cardio-vascular disease	2 years
	(c) Arterio-sclerosis	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 8-2-49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Aug. 4, 1949 NAME OF CEMETERY OR CREMATORY Scotts Rem LOCATION (City, town, or county) Shady Side (State) Md.

DATE REC'D BY LOCAL REG. Aug - 2 - REGISTRAR'S SIGNATURE J. B. Dent
24. FUNERAL DIRECTOR H. E. Hardesty & Son ADDRESS Edgewater Md.

VS. A15A

RECEIVED
AUG 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07513

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Pasadena
LENGTH OF STAY (in this place) 13 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mountain Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY N. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Pasadena
STREET ADDRESS (If rural give location) Mountain Road.

3. NAME OF DECEASED (Type or Print) (First) ELLA (Middle) CLARA (Last) SHELTON

4. DATE OF DEATH (Month) August (Day) 30 (Year) 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED (Specify) DIVORCED,

8. DATE OF BIRTH July 25 1858

9. AGE last birthday 91 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY H. W.

11. BIRTHPLACE (State or foreign country) Morefield West. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Junius Maupin

14. MOTHER'S MAIDEN NAME Anna Houseworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Lucullus Shelton (Son).

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 8 years.

151

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/28, 1949, to 8/30, 1949, that I last saw the deceased alive on 8/28, 1949, and that death occurred at 9:50 A.m., from the causes and on the date stated above.

SIGNATURE Bobby L. Jones, M.D. (Degree or title) ADDRESS 7 Central Ave. S.W. Glen Burnie Md DATE SIGNED 8/30/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF September, 1949 NAME OF CEMETERY OR CREMATORY Shelton Family Burial Ground LOCATION (City, town, or county) Standardsville, Greene Co. (State) Va

DATE REC'D BY LOCAL REG. 8/31/49 REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07514

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eldridge P.O
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Patapsco village

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
STREET ADDRESS (If rural, give location) Winter Ave. ✓

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Bernard (Last) Smith
4. DATE OF DEATH: (Month) Aug. (Day) 1 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) single
8. DATE OF BIRTH: 8-18-1931
9. AGE last birthday: 17 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Cafeteria
11. BIRTHPLACE (State or foreign country) Catonsville
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Melvin Smith
14. MOTHER'S MAIDEN NAME Gertrude Toomey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ✓

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Drowning	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Accidental	
929.8 1860	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Property of Arundel Sand & Gravel Co.
(CITY OR TOWN) Patapsco (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Done into about 8 feet of water

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Caffy M.D. Deputy Medical Examiner Annapolis Md 8-1-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 8-5-49
NAME OF CEMETERY OR CREMATORY Arbutus Mem.
LOCATION (City, town, or county) Balto. Co.
(State) Md.

DATE REC'D BY LOCAL REG. 8-5-49
REGISTRAR'S SIGNATURE H. W. Hedrick
24. FUNERAL DIRECTOR Mrs Frances A. Hensley
ADDRESS 578 Biddle St

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

07515

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Nutwell
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Janie (Middle) J. (Last) Smith
4. DATE OF DEATH (Month) Aug (Day) 11. (Year) 1949
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Unknown
8. DATE OF BIRTH: Jan 1, 1892
9. AGE last birthday: 57 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no
16. SOCIAL SECURITY No.: no
17. INFORMANT AND ADDRESS: Percy Blake

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Myocarditis — 1 year

450.0 Antecedent cause(s) (b) Arterio-Sclerosis — 2 yrs

93a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 15, 1948, to Aug 14, 1949, that I last saw the deceased alive on Aug. 11, 1949, and that death occurred at 11:30 A.M. m., from the causes and on the date stated above.

SIGNATURE: J. L. Richardson MD (Degree or title)
ADDRESS: 110 - Clay St., Annapolis, Md.
DATE SIGNED: 8/12/49

23. BURIAL, CREMATION REMOVAL (Specify): DATE: Aug 14, 1949
NAME OF CEMETERY OR CREMATORY: Friendship Cem.
LOCATION (City, town, or county): Friendship (State): Md

DATE REC'D BY LOCAL REG.: Aug 13
REGISTRAR'S SIGNATURE: I. B. Dent
24. FUNERAL DIRECTOR: T. A. Stardrop & Son
ADDRESS: Galesville Md

RECEIVED
AUG 16 1949
BUREAU V. S.

07516

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural - pasadena
LENGTH OF STAY (in this place) 72 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS none

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural, Pasadena, Md.
STREET ADDRESS (If rural give location) rural - off Mountain Road.

3. NAME OF DECEASED (Type or Print) (First) EDWARD (Middle) NONE (Last) SPENCER
4. DATE OF DEATH (Month) 8 (Day) 12 (Year) 1949

5. SEX MALE
6. COLOR OR RACE NEGRO
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH 1877
9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) ANNE ARUNDEL COUNTY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME MARYLAND TURNER
14. MOTHER'S MAIDEN NAME HARRIET SPENCER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT AVIS MACEY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) HEART FAILURE	5 DAYS.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ARTERIO SCLEROSIS.	
	(c)	

450.0
97

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE.

19a. DATE OF OPERATION NONE
19b. MAJOR FINDINGS OF OPERATION NONE
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE (CITY OR TOWN) (COUNTY) (STATE) NONE
TIME OF INJURY (Month) (Day) (Year) (Hour) NONE m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? NONE

22. I hereby certify that I attended the deceased from Aug. 29, 1949, to Aug 12, 1949, that I last saw the deceased alive on Aug. 5, 1949, and that death occurred at 6:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Randall M. McLaughlin, M.D. Pasadena P.O. Md. Aug. 12, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/14/49
NAME OF CEMETERY OR CREMATORY Marley Neck Ct
LOCATION (City, town, or county) (State) A. A. Co., Md

DATE REC'D BY LOCAL REG. 8/12/49
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR D. L. Brown & Son 108 W Montgomery St ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07517

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) D.O.A.; HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNAPOLIS Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 5718 Beauregard Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ANNA	DOROTHEA	TAYLOR	Aug.	10	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	White	married	APR. 4, 1889	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housekeeper	Home	Maryland	U.S.A.

13. FATHER'S NAME Phillip C. Volk

14. MOTHER'S MAIDEN NAME Catherine Dressel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT Robert T. Taylor

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 934	(b) Coronary sclerosis	3 years or more
	(c) Cardio-vascular hypertensive disease	3 years or more
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Lafty M.D.	Deputy Medical Examiner	Annapolis Md.	8-10-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	AUG 13 49	EMMANUEL	BALTO.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/11/49	C. W. Hedrick	L. HECHMANN & SON	6067 Harford Rd.

VS. A15A

08307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 67 North West St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 67 North West St.

3. NAME OF DECEASED (Type or Print) (First) Cornelius (Middle) H (Last) Thomas
4. DATE OF DEATH (Month) 8 (Day) 21 (Year) 1949
5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 9-7-1899
9. AGE last birthday 49 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Cook)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles H. Simpson
14. MOTHER'S MAIDEN NAME Sarah Thomas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Alverta Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive Heart Failure

434.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

93e (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Annapolis (COUNTY) dd (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-19, 1949, to 8-21, 1949, that I last saw the deceased alive on 8-20, 1949, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

SIGNATURE R. T. Allen (Degree or title) M.D. ADDRESS 10 Carroll DATE SIGNED 8-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8-25-49
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) Annapolis (State) Md.
DATE REC'D BY LOCAL REG. Aug 24, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR William Reese, II ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07518 Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) 10 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 Franklin St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 9 Franklin St.

3. NAME OF DECEASED (Type or Print): (First) Lenz (Middle) Marie (Last) Thomas

4. DATE OF DEATH: (Month) August (Day) 12 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7-19-1879

9. AGE last birthday: 70 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Matthew Strohm

14. MOTHER'S MAIDEN NAME: Louise Lodiger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Carl S. Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Congestive Heart Failure	6 months
465 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary Infarction Left Lung	"
111a	(c) General asthenia	"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Sub-acute nephrosis	"

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 8, 1949, to Aug. 11, 1949, that I last saw the deceased alive on Aug 11, 1949, and that death occurred at 12 45 P. m., from the causes and on the date stated above.

SIGNATURE: John M. Claffy (Degree or title) M.D. ADDRESS: Annapolis, Md DATE SIGNED: 8-12-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE THEREOF: 8-14-49; NAME OF CEMETERY OR CREMATORY: Cedar Bluff; LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: Aug. 14, 1949; REGISTRAR'S SIGNATURE: W. D. Smith; 24. FUNERAL DIRECTOR: John B. Layhe Son; ADDRESS: Annapolis Md.

VS. A15

RECEIVED
AUG 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07519 26

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred: At Home

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: A.A.

City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Lillian Trott

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6.(b) Name of husband or ~~wife~~: Samuel Elsworth Trott

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years 66 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Owing Md
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: John James Grover
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth C. Stevens
15. Birthplace: Md.

16. Informant: Mr Andrew Grover

Address: Owings Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6, 49 (month) (day) (year)

Cemetery or crematory: Miranda

Location: Huntingtown

18. Funeral director: Wm H Hutchins

Address: Owings Md

18. Aug 5 1949 (Date rec'd by registrar) Grace L. Hutchins Registrar
Tte B. Dent

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/4 1949, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/2 1949, to 8/3 1949 and that I last saw her alive on 8/3/49 19

Immediate cause of death: Chr. myocarditis

Due to

Due to

Other conditions: 422.2 93d
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Huntingtown Md Date signed: 8/4/49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

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RECEIVED
AUG 9 1949
BUREAU T. I.

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07520

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis (RURAL)
STREET ADDRESS (If rural give location) 1032 West St.

3. NAME OF DECEASED (Type or Print) (First) Carrie (Middle) M. Tuers (Last) Tuers

4. DATE OF DEATH (Month) Aug (Day) 30 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)~~
8. DATE OF BIRTH 11/5/1905
9. AGE last birthday 43 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mayo AA. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME W. W. Lewis
14. MOTHER'S MAIDEN NAME Irene Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Charles Roy Tuers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis generalized	6 months
170 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma left Breast	1946
50	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1946
19b. MAJOR FINDINGS OF OPERATION Carcinoma left Breast
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1946, to Aug 29, 1949, that I last saw the deceased alive on Aug 29, 1949, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 8.30 49.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~
DATE THEREOF 9-1-49
NAME OF CEMETERY OR CREMATORY Mayo Memorial
LOCATION (City, town, or county) Mayo AA Co (State) Md

DATE REC'D BY LOCAL REG. Sept. 1, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor-Son ADDRESS Annapolis Md.

RECEIVED
SEP 2 1949
BUREAU V. S.

Kirsby 202

07521

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Shore (Pasadena, Md.) LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Shore (Pasadena, Md. P.O
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Nathan (Middle) J. (Last) Utterback
4. DATE OF DEATH (Month) Aug. (Day) 24 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 26, 1894
9. AGE last birthday 55 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realestate
10b. KIND OF BUSINESS OR INDUSTRY self
11. BIRTHPLACE (State or foreign country) Jackson, Mich.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Hiram Utterback
14. MOTHER'S MAIDEN NAME Louise Winegar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W. W. I
16. SOCIAL SECURITY NO. 218-18-2488
17. INFORMANT Mrs. Helen V. Utterback

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Coronary Thrombosis — Interval Between Onset and Death: Suddenly

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Cardio Vascular Disease

93d (c) Cardiac Dilatation Obesity.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1945, to Aug 24, 1949, that I last saw the deceased alive on Aug 23, 1949, and that death occurred at 4.00P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Joseph Lipsky M.D. ADDRESS Edenton Md DATE SIGNED 8/24/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug. 26, 49
NAME OF CEMETERY OR CREMATORY Baltimore National
LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. 8/26/49
REGISTRAR'S SIGNATURE L. J. DeAlba
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
AUG 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07522

CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

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VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
LENGTH OF STAY (in this place): 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 100 Crain Highway S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
STREET ADDRESS (If rural, give location): 100 Crain Highway, S.W.

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) MAY (Last) WARD

4. DATE OF DEATH: (Month) Aug. (Day) 24 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 8, 1886

9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cambridge, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Hanson Bradley

14. MOTHER'S MAIDEN NAME: Ellen Phippen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Miss Dorothy Ward

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized Carcinomatosis — 6 mos.

170 / 50 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma, Breast, Left — 1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/25, 1949, to 8/25, 1949, that I last saw the deceased alive on 8/25, 1949 and that death occurred at 8.15 A. m., from the causes and on the date stated above.

SIGNATURE: Rev. Richard (Degree or title) M.D. ADDRESS: Glen Burnie, Md. DATE SIGNED: 8/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Aug. 26, 49.

NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

LOCATION (City, town, or county) (State): Brooklyn, R.F.D. Md.

DATE REC'D BY LOCAL REG.: 8/26/49

REGISTRAR'S SIGNATURE: L. J. Drach

24. FUNERAL DIRECTOR: Thomas W. Singleton ADDRESS: Glen Burnie, Md.

RECEIVED
AUG 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

17524

Reg. Dist. No. 22

M — The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel R. F. D.; MARYLAND; LENGTH OF STAY (in this place) 50 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel R. F. D.; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) REZIN (Middle) C (Last) Whitehead

4. DATE OF DEATH: (Month) Aug (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct 26 1868

9. AGE last birthday: 80 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Whitehead

14. MOTHER'S MAIDEN NAME: Susie Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Henrietta Whitehead.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Cardiac Dil.	1 d
422.1 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	3 yr.
	(c) Myocardial Weakness	3 yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-16, 1949, to 8-2, 1949, that I last saw the deceased alive on 8-2, 1949, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B Adams Laurel Md

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 6 1949	Ivy Hill	Laurel Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 6-49	Clara Rathell	Ridgley Selby	401 Wash. ave Laurel Md

VS. A15

RECEIVED
SEP 0 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07525

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 900 Edmondson Ave. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ANGELETTE	CHRISTINE	WOODING	Aug.	6	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	negro	✓	7-18-05	44 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MAID	DEPT. STORE	MIDDLESEX Co., VA.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE WEST	JANA HENRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		HAROLD WOODING - 900 EDMONSON AVE.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	Sudden
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial - hypertension	3 years
830	(c) Arterio - sclerosis - (general)	3 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Claffy M.D.	Deputy Medical Examiner	Annapolis Md	8-6-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
SHIPPED	8-10-49	GRAFTON CHURCH	MIDDLESEX Co., VA.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/8/49	A. W. Hedrick	Wm. A. JACKSON	916 PENNA. AVE.